

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-27-04.

The IRO reviewed office visits, manipulations, therapeutic exercises, therapeutic procedures, massage, ultrasound, neuromuscular re-education, group therapy, mechanical traction, gait training, manual therapy and supplies rendered from 11-19-03 through 03-26-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the ~~paid IRO fee.~~

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-30-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 date of service 03-08-04 denied with denial code "F/TD" (work status report was not properly completed or was submitted in excess of the filing requirements, therefore, reimbursement is denied per Rule 129.5). The requestor did not submit documentation for review. No reimbursement recommended.

This Decision is hereby issued this 2nd day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

January 3, 2005

TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT:

EMPLOYEE:

POLICY: M5-05-0656-01 5278

CLIENT TRACKING NUMBER: M5-05-0656-01

AMENDED - 1/31/05

AMENDED - 1/14/05

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

Records Received:

Records received from TWCC

Notification of IRO Assignment dated 11/30/04

IRO assignment of Independent Review Organization dated 11/30/04

Medical Dispute Resolution Request/Response dated 10/27/04

Page with provider name and addresses

Table of Disputed Services dated 11/19/03 to 3/26/04

Explanation of Benefits

Records received from Suhail Al-Sahli, DC

Letter from N.B.C Healthcare Center to Medical Review Institute of America dated 12/8/04

Office notes from C.L. C. Chiropractic Center, Inc. dated 8/23/03 to 2/2/04

Daily notes report from N.B.C Healthcare Center dated 3/29/04 to 4/21/04

Office notes from Texas Pain Solutions dated 9/26/03 and 11/14/03

Medicine listing from Texas Pain Solutions dated 7/18 to 12/5

Prescription from Texas Pain Solutions dated 12/3/03

Progress notes from Texas Pain Solutions dated 2/18/04

SOAP notes from Texas Pain Solutions dated 12/5/03 to 1/28/04
Progress notes from Texas Pain Solutions dated 8/8/03 to 11/14/03
Initial visit comprehensive evaluation report from Texas Pain Solutions dated 7/18/03
MRI of lumbar spine report dated 7/25/03
MRI of left foot report dated 7/25/03
MRI of left ankle report dated 7/25/03
Letter from Guy R. Fogel, MD to Suhail S. Al-Sahli, DC dated 4/15/04

Summary of Treatment/Case History:

Date of Injury is _____. Service for treatment begins 11/19/03 and continues until 3/26/04. Patient is treated with multiple meds, multiple modalities on the same day throughout these dates of service. The patient shows little to no improvement over this time.

Questions for Review:

1. Please advise medical necessity of the office visits, manipulations (#98940, #98941), therapeutic exercises, massage, ultrasound, neuromuscular re-education, group therapy, mechanical traction, gait training, manual therapy (#97140), therapeutic procedures (#97150) and supplies (#99070) on 11/19/03 thru 3/26/04.

Explanation of Findings:

Findings appear to be that injury occurred on _____. This patient started treatment with this facility on 11/19/04. There is over a 4-month gap between injury and treatment at this facility. Furthermore, stated in the findings of Dr. Suhail Al-Sahli D.C, there are no significant findings on the past patient history of this injury. X-rays were ordered. A review of the x-ray and MRI have been completed. This still does not change the fact that injury occurred on ____ and treatment begins on 11/19/03. The reading of MRI and x-ray also do not change that documented notes report that the patient shows little to no improvement over treatment time, with no alteration or updating to treatment plan or referral. but there is no report or documentation regarding them. There is no MRI listed as being ordered and no MRI report. A patient whom is treated for this length of time with multiple modalities needs to be monitored for improvement. This patient showed little to no improvement, and is documented in several days she was worse, yet I see no inclusion for the order of further diagnostic testing. The patient was continually given multiple prescriptions for medication, and the same modalities that were yielding poor to no results continued.

Conclusion/Decision to Not Certify:

1. Please advise medical necessity of the office visits, manipulations (#98940, #98941), therapeutic exercises, massage, ultrasound, neuromuscular re-education, group therapy, mechanical traction, gait training, manual therapy (#97140), therapeutic procedures (#97150) and supplies (#99070) on 11/19/03 thru 3/26/04.

Treatment noted above is not medically necessary and there is overutilization.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

Tureks Guide to Orthopaedics

Soft Tissue Rheumatic Pain – Sheon, Moskowitz, Goldberg.

References Used in Support of Decision:

See above.

The physician providing this review is board certified in chiropractic medicine. The reviewer also holds additional certifications in Acupuncture and Orthopedics. The reviewer is a member of their state chiropractic association and is certified to provide reviews for the workers compensation commission as a designated doctor, RME and IME. The reviewer has been in active practice since 1998.

MRloA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRloA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRloA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRloA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRloA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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